



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RIO VISTA REHAB HOSPITAL
1500 S. DOUGLASS RD
ANAHEIM CA 92806

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-08-1935-01

MFDR Date Received

NOVEMBER 9, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please allow this letter to service as a formal appeal in response to the above referenced underpaid claim. Medically necessary services were rendered to your member as ordered; yet, reimbursement of the claim was not in accordance with the contract terms agreed upon by our facility and your organization. It is requested that you remit additional payment immediately. The following documentation supports our position: The attached claim was partially denied for no authorization. On 11/13/06 we spoke with Bertha Garbriel and received authorization for Eval & treatment [sic], phone # 888-777-4789. A copy of our notes showing verbal authorization is attached as well as the UB92 & itemization, medical records and the EOB for your review. Please process for the expected reimbursement of \$436.03."

Amount in Dispute: \$436.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has prev pd \$125.42 – Carrier agrees to pay add'l \$178.39 please see attached-"

Response Submitted by: Specialty Risk Services, 300 S. State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
11/13/06 11/15/06 11/22/06 11/27/06	Outpatient Hospital Services 97035-GO, 9711GO, 97530-GO, 97003-GO	\$436.03	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology. Reduced to fair and reasonable.
 - W1 – Workers Compensation state fee schedule adjustment. PT/OT services requires pre-authorization after initial treatment (6 visits) [sic] following the DOI. If pre authorization was received reimbursement is made in accordance with TX MFG.
 - W3 – Additional payment made on appeal/reconsideration. Reimbursement for your resubmitted invoice is based upon documentation and/or additional information provided.
 - 193 – Original payment decision is being maintained. Final action. In accordance with Rule 133.250(G): "A health care provider shall not resubmit a request for reconsideration after the carrier has taken final action on the request."

Findings

1. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(c)(2)(C), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division." Review of the Table of Disputed Services finds that the health care provider did not complete the Table of Disputed Services by completing the Total Amount Paid and Amount in Dispute columns and the CPT Codes used on the table do not reflect the UB, with the exception of CPT Code 97530. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under §133.307(c)(2)(C).
4. 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "a description of the health care for which payment is in dispute." Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).
5. 28 Texas Administrative Code §133.307(c)(2)(F)(ii), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "the requestor's reasoning for why the disputed fees should be paid or refunded." Review of the submitted documentation finds that the requestor has not stated the reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(ii).
6. 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The

Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).

7. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
8. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "reimbursement of the claim was not in accordance with the contract terms agreed upon by our facility and your organization."
 - The requestor did not submit documentation to support that a contract exists between the requestor and respondent.
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
 - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 31, 2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.